



DEPARTMENT OF THE ARMY
U.S. ARMY MEDICAL DEPARTMENT ACTIVITY
FORT BELVOIR, VIRGINIA 22060-5901

REPLY TO
ATTENTION OF

MCXA-PI

25 May 2004

MEMORANDUM FOR RECORD

SUBJECT: After Action Report for April 2004 Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Survey of the U.S. Army Medical Department Activity, Fort Belvoir, VA.

1. This memorandum presents an overview of the May 18-21, 2004, U.S. Army Medical Department Activity (MEDDAC), Fort Belvoir, Virginia survey experience. Presented is a summary of the major components of the survey and a representation of the process and questions posed. The MEDDAC was surveyed simultaneously for accreditation under the Hospital and Behavioral Health accreditation manuals.
2. The survey consisted of four hospital and one behavioral health survey days. There were four surveyors, a physician (retired Navy Captain and background in Otolaryngology), a nurse (Performance Improvement and Patient Safety background), and an administrator/ambulatory survey (retired Army Colonel). Our behavioral health program was surveyed by a fourth surveyor (Psychologist) on 18 May.
3. Two weeks prior to our survey date the Priority Focus Areas (PFA) for the survey were posted on the Joint Commission's extranet site. The report listed five PFAs, which included information management, communication, staffing, and quality improvement expertise/activities. Also identified in this report were five clinical service groups applicable to the services provided at this MEDDAC. These included general surgery, general medicine, otolaryngology, gastroenterology and orthopedics.
4. To present an overview of the survey, a brief description of those who attended each session, the general discussions held, and points of interest are presented below for each survey activity identified on our survey schedule. The enclosure to this memorandum contains the surveyor recommendations and examples of the questions asked during the individual tracer activities.

a. Opening Conference and Orientation to the Organization. This combined session lasted approximately one hour. Attendees included all surveyors, the Command Staff, Chief of Primary Care, Chief of Behavioral Health, the Performance Improvement Coordinator, Patient Safety Manager, Nurse Methods Analyst, and all four escorts and four scribes. There were also three observers and a Joint Commission Fellow in attendance. After a brief introduction of all participants, the lead surveyor

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briefly spoke about the new survey process. The orientation to the organization was made by the Commander. After the presentation, the surveyors asked points of clarification and the session concluded.

b. Surveyor Planning Session. The surveyors were individually provided with a list of patients, the Operating Room schedule and Endoscopy Suite schedule. This list was prepared by PAD and included patient name, age, diagnosis and ward assigned. A new set of lists were generated each morning and presented to the surveyors. During the planning session, the nurse surveyor requested data related to resuscitation outcomes, restraint usage, compliance with the National Patient Safety Goals (specifically patient identification, Do Not Use abbreviations, Time Out in the Operating Room and other, site marking in the Operating Room and other, Hand Hygiene compliance), Staffing Effectiveness, Restraint Education, Lab Quality Control data (specifically, glucose), End of Life data. Additional data requested was the previous year's ECMS (Executive Committee of the Medical Staff) minutes as well as Clinical Administrative Steering Committee minutes. During each day of the survey additional items were requested to include Adverse Drug Reaction data, Pharmacy interventions/100 admissions, medication error data, list of all credentialed providers, medical record delinquency rate, one years worth of infection control minutes, a list of people authorized to do waived testing and what tests they were authorized to do, a list of personnel authorized access to the Omnicell, medication management data, blood and blood product use data, and operative and other invasive procedures data. Several policies were requested throughout the survey to include Code Management, Pain Assessment and Management, Range Medication, and Nutrition Screening. The Environment Of Care (EOC) management plans and a collection of 12 months of EOC minutes were requested and previously left with the surveyors. The surveyors remained secluded in their office to plan the day's activities during the initial planning session. The behavioral health surveyor quickly departed to begin the behavioral health survey.

c. Special Issues Resolution. These were scheduled daily near the end of each day. There was no specific activity during this scheduled time of the survey.

d. System Tracer: Data Use. This session took place on the second day of the survey and was led by the Administrator Surveyor. The session focused more on our performance improvement processes than expected. There was no apparent expectation to present data, but to discuss what data we do collect and what we do with the information pulled from the data. Specific data that was requested to be discussed was medication management, adverse drug reaction, blood and blood product use, restraint use, resuscitation and its outcomes, operative and other invasive procedures and ORYX data.

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e. System Tracer: Medication Management. The physician surveyor facilitated this discussion on the third day of the survey. Assigned to participate in this session were the DCCS; Chief, Pharmacy Services; Chief, Family Practice; ADCN; CRNA; Chief, Emergency Medicine; HN, ICU; HN, Mother & Baby; Chief, Nutrition Care Division; Inpatient Pharmacy Supervisor; Infection Control Nurse; HN, DeWitt Family Practice Clinic; Representative, Logistics/Omniceil Administrator. Discussion began with several questions:

- How many doses are given in the hospital per month?
- How many steps are involved in any order for medication?
- How many of the patient safety goals have to do with pharmacy?
- What is your mechanism for medication error reporting?
- What do you consider a near miss? Do you keep track of them?
- Someone involved in treating patients, describe a near miss you have had.
- Is a pharmacist on duty 24/7?
- Is anyone allowed in the pharmacy after hours?
- What do nurses do if they need medications after hours?
- What part of medication management is most concerning?

f. Environment of Care Session. The administrative surveyor was provided the seven management plans and the previous twelve months of Environment of Care committee minutes early in the survey process. This session was attended by our Chief of Logistics; Facility Management; and Chief of Planning, Operations, Mobilization, and Security. Also in attendance were the Patient Safety Manager, Environmental Services Officer, Safety Manager, and Security Manager.

The surveyor reviewed the new format for JCAHO survey

- self-evaluation in 15-18 months to establish plan
- looking for deficiencies identified and plans in effect
- asked about the number 1 concern for EOC committee
- asked about tracking of occupational illness/injuries

Reminder to get in habit of setting goals in %, days, dollars--not just "reduced"

Security Management

- what are you measuring?
- suggested building accountability

Hazmat

- what are you measuring?
- asked about chemotherapy/radiology

Infection control

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- what are you measuring?
- asked if recycling one-time use items
- Life Safety/Fire Prevention
 - asked about accountability of fire drills
 - What will be done?
 - How are people tested?
 - The surveyor suggested more thorough education of ALL staff to include smoke doors, fire floors, penetrations, etc.
- Security/Infant abduction
 - Questions about last drills for abductor profiles and drills from ED
- Asked about PM completion rates, user error management and unscheduled work orders/year
- Asked about clinical alarms
 - suggested competitive noise testing of alarms
- Asked about emergency generators and testing procedures
 - asked about redundant backup battery systems
- Emergency Preparedness/Hazard Vulnerability Analysis
 - asked what was measured on recall
 - asked for top 3 priorities
 - asked about HVA compliance

g. **Leadership Session.** This session, held on the final survey day, was attended by the Command Staff, Performance Improvement Coordinator, Patient Safety Manager, Assistant ADCN, Chief, Primary Care, Chief, Clinical Informatics. All three surveyors attended this session and participated in the discussion. There was little if any discussion regarding formal performance improvement processes. A summary of the session's questions follow:

- All persons present were asked to discuss what each of them was most concerned about.
- How does the command ensure staff members are ready to work after being assigned?
- Have there been issues with contract staff?
- How does the command lead versus manage and how does the command build confidence in the staff?
- How does the command build accountability?

h. **System Tracer: Infection Control.** This session was held on the final day of the survey and was led by the nurse surveyor. Earlier in the day, the surveyor asked for the

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previous year's Infection Control minutes. The session was attended by the Infection Control Officer; DCN; Assistant DCN; OR Staff member; Chief, Pharmacy; Surgeon (Chief of Surgery); Logistics – Chief of Materiel Branch; Community Health Nurse – HIV Program coordinator; Occupational Health Nurse Manager; Patient Safety Manager; Lab/Micro supervisor; Safety Manager; Satellite facility IC Nursing and Education representatives; Chief, Environmental Services; Chief, Environmental Health; Industrial Hygiene. The surveyor noted that despite many changes in the standards and the process, the IC Interview will remain basically the same as always. A review of the session is as follows:

How do you monitor physician prescribing patterns and RX for Community–Acquired Pneumonia (CAP)?

Does Pharmacy have an auto check against the lab? [In other words, do they compare the drug ordered with the bug?]

The surveyor had already seen the ORYX data re the timing of antibiotic prophylaxis and addressed our compliance.

Are Pharmacy interventions documented?

Asked if the IC Officer had ever looked at the exact timing for the administration of antibiotics given by the inpatient nursing staff? For example, when the dose is missed and they have to re-time the doses – If drug is ordered to be given at 1000, is it hung at 0920; 1045 or 1130? She recommended that we document the average time of variance and try to improve.

Tell me about your CAPs. What do you monitor? – Time from entrance in the ER to diagnosis pneumonia - to first dose antibiotic – then we also monitor smoking cessation, are blood cultures drawn before antibiotics started – As a result of networking with civilian hospitals in the area, we are going to incorporate their clinical practice guidelines into our computer system to facilitate MD compliance with these standards.

Tell me about your Emergency Preparedness for Bioterrorism?

- Discussion re the development of the Smallpox plan – the training, development of policies for Infection Control, PPE and cleaning/disinfecting requirements, dressings and protection for family and patients from the spread of vaccinia. .
- The Northern Virginia Alliance was discussed
- The connection with the Maryland Dept of Health BLAST FAX and alerting system
- The Public Health Emergency Preparedness Plan – which buildings on post would house patients – how to notify them, transport patients, etc.

How was it determined who would be vaccinated?

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MASCAL – What contingency has been put in place?

Are we set up for the decontamination phase?

How was it determined who would be vaccinated?

Asked the group to respond: “What infection risk have you identified in your area – corrected – (how?) And then... what were the results?

How do you know the providers are washing their hands?

i. **Competence Assessment Process.** This session was held on the final day of the survey and was led by the nurse surveyor. The day prior, we were provided with a list of 9 personnel for whom the surveyor wanted to see competency folders. The list consisted of the ICU HN, ICU LPN, two staff members from the ED, PACU RN, MRI Tech, two staff from the lab, and a contract staff from the medical/surgical ward. The lab and PACU staff were selected by position. The rest were selected by name. We were requested to tab the following in each folder: current evaluation due date and completion date; current health screening; competency check prior to independent duty; department orientation; patient safety training to include the National Patient Safety Goals and medication errors; for Registered Nurses- the competency checklist, glucose competency, HCG testing, ABG's, and restraint use. The session was attended by members of the Human Resource Functional Management Team, Credentials Coordinator, PI Coordinator. The surveyor reviewed all of the requested competency folders following the session. Credentials records were not requested during this session. The majority of the questions centered upon staff's initial and ongoing competency assessment processes. Staffing Effectiveness was a major topic discussed during this session. Questions during this session were as follows:

STAFFING AND COMPETENCIES:

Staff competencies are checked based on patients traced

How do you screen staff coming in?

How do you check annual competencies?

How do you orient staff to facility; work area?

Do you have set criteria for the person they're reporting to?

What does the unit do when they get the new staff member?

Does someone assess competencies; who can validate; it should be someone with equal or higher training?

How do you handle age specific competencies?

Is the method of validating the competency documented in the folder?

How do you determine what training is required?

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What data do you use to determine that there's a need for training?

If someone is not performing to par and requires corrective action, what data are you collecting to identify trends and patterns?

What behaviors are staff falling down on with their evals; collect data from your evaluations to see if there are trends

STAFFING EFFECTIVENESS:

What disciplines affect whether nursing can get things done (in relation to patient care)?

Look at pharmacy when they're not available vs. during the duty day

Lab and respiratory therapy also affect nursing staff

What clinical indicators would you use to evaluate the effect of doing other duties vs. nursing duties?

Look at indicators sensitive to population

Consider peak times in ED

Consider housekeeping

Document why you made changes

j. **Credentialing and Privileging Process.** This was the final session held and was led by the physician surveyor on the final day of the survey. The session was attended by members of the Credentials Committee. A list of credentialed providers was requested on the first day of the survey. The day prior to the survey, 13 credentials folders were requested. Nearly all of these were requested by name. These included folders for the following: Chief, Emergency Services, Family Practice Resident, Nurse Midwife, Urologist, ER Physician, General Surgeon, Orthopedic Surgeon, CRNA, 2 Family Practice Physicians, Physician Assistant, Pediatrician, and a Podiatrist. Questions during the session were as follows:

What is the process for credentialing?

How do handle impaired providers?

Does your organization have a physician well-being committee?

Is there a separate peer review file for each credentialed provider?

Is it a requirement to have a DEA number?

What does the organization do if a physician reports post residency without a license?

A nurse practitioner was asked to discuss credentialing within the Department of Nursing.

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k. **Individual Tracer Activity.** The individual patient tracers were selected by the surveyors from the lists provided. There was no great surprise in the patients selected. Those selected were complex. Each surveyor was accompanied by an escort, scribe, and runner. The surveyors began the tracer at the point at which the patient presented for care. Surveyors were eager to speak with healthcare providers and staff who directly provided care to the patients. The surveyors did not follow a predictable path through the clinic. There was no advanced notice of the time of the surveyor's arrival in a clinical area; and areas were frequently visited on multiple occasions throughout the survey. Descriptions and comments of the individual tracer activity are provided in the enclosure.

l. **Behavioral Health Care Interim Exit Conference.** This session was conducted at the end of the day on the first day of the survey and was led by the Behavioral Health surveyor. She presented areas for improvement and provided an opportunity for all in attendance to discuss her findings. At the conclusion of the complete survey, the results of the Behavioral Health survey are incorporated into the comprehensive and final survey report. The surveyor then departed following the days activities.

m. **Exit Briefing/Conference.** An exit conference was held among the surveyors and the MEDDAC Command Group, Performance Improvement Coordinator and Patient Safety Manager. At this meeting, the Commander was presented with the preliminary findings of the accreditation survey. These were included in the Preliminary Report to follow.

5. The **Preliminary Report** left by surveyors listed four Requirements for Improvement (one of which was flagged for review), and three Supplemental findings, per below:

a. **Standard PC.3.120:** The clinical records of two ASAP patients did not contain clinical formulations or conclusions or diagnostic summaries of the data contained in the bio-psychosocial assessments.

b. **Standard PC.2.120:** The rules and regulations of the Medical Staff state that an History and Physical for a patient previously admitted is good for 30 days and that if the patient is readmitted, an interim progress note is required. For elective surgical patients, the History and Physical may be completed up to 30 days prior to the scheduled surgery; however, an interim updated assessment is not required and none were noted in surgical patient tracers carried out.

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c. **Standard HR.1.10:** Clinical Supervisor position with the ADAP program has been vacant in excess of two years and the two substance abuse counselors have been performing the responsibilities of the vacant position.

d. **Standard EC.5.20: Flagged Standard.**

Standard EC.A.4D.2: Four vertical conduit penetrations identified in the 6th floor during the building tour were corrected during the survey.

Standard EC.A.6F: Seven chairs, which were not on wheels and readily moveable, observed during the building tour in the exit corridor of the basement. On the second day of the survey, four additional chairs were observed in another corridor in the basement.

Identified Supplemental Findings:

a. **Standard IM.6.40:** In two instances, the Master Problem list had not been completed or was incomplete.

b. **Standard LD.4.70:** The organization has implemented the “time-out” for operative and invasive procedures. Compliance data is available for the OR areas. For areas outside the OR, the “time-out” is documented; however, the data has not been collected, aggregated or analyzed to determine compliance.

c. **Standard HR.1.30:** The hospital’s selection of direct and in-direct caregivers for staffing effectiveness is focused in nursing services with one exception – pharmacy. The direct and indirect caregivers include RN’s, LPN’s, NA’s and pharmacy staff. Other disciplines / categories of staff that may impact staffing were not included in the data collection and analysis. For example unit clerks, housekeeping staff, phlebotomist, transporters, Dietician and Physical Therapists.

6. The point of contact for this memorandum is the undersigned at (703)-805-0397 or by email at Barbara.harris@na.amedd.army.mil.

Encl: 1

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Performance Improvement

**U.S. Army Medical Department Activity
Fort Belvoir, Virginia**

2004 Joint Commission Survey Process Notes

These notes represent those taken by the scribes assigned to each surveyor.

SURVEY DAY ONE – 18 May 2004

Behavioral Health Surveyor Activities

A summary of the questions and tracer activities follows:

What kind of formal staff JCAHO training done with Service Chiefs?
Who did your last survey by name?
What is the Clinical Administrative Steering Committee?
Who was the last hire in the department?
What are your 2 top diagnoses?
How many staff to Patient ratios?
How do bridge referrals work?
What is the difference between BH and ASAP records, how does that bridge work with referrals into the medical record?
How many records are reviewed per provider per month?
How do patients get appt into BH? Who does the intake screening?
Who does site testing?
Where do the files go after a patient's case is closed?
When do ASAP patients see a psychiatrist?
Where do you keep the "Do Not Use Abbreviation List"?
What medications are given?
What are the caseloads for psychiatrist, psychologist and socialworkers?
What kind of monthly meetings do you hold?
How are you continuing competency measures?
When is peer review done and how many charts a month?
How long do patients wait for an appt generally?
What are your PI projects?
Show me the new electronic forms.
When do patients get new intake assessments?
Does the Garrison's ASAP program work in conjunction with DeWitt's?
What is a typical treatment plan review?
What is your service area?
How do you refer out to the civilian programs?
How does the BH staff triage the right patient for the right treatment?
When are your rehab meetings?

Two patient tracers were conducted:

Tracer 1 Complex Inpatient/ ASAP patient—look to see the pattern of referral to Nutrition, Labs, Pharmacy, Radiology, Health Screenings, diagnostic summaries
Surveyor actually did see Tracer 1 patient personally.

Tracer 2 Outpatient/ ASAP—looked at 14 page Intake record, history, signatures, legal documents, written diagnosis assessments, forms cross-walked to convenience file and ASAP file and medical record, progress notes.

Physician Surveyor Activities

A summary of the questions and tracer activities follows:

Medical/Surgical Ward

How many beds were present on the ward and what is the current census?

Patient Tracer: patient admitted through the ER for a rule out DVT.

Surveyor noted that there was an inconsistency between the CIS note and the 558.

Surveyor stressed the importance of communication between the ER and the nursing ward.

Surveyor went into CHCS to check the lab and pharmacy reports.

Dietician was then asked questions about nutrition care and what her responsibilities were.

On surveyor's arrival to unit the Head Nurse, Dietician and Case manager were involved in a discharge-planning meeting. The surveyor requested to sit in on the rest of their meeting.

Surveyor then addressed the staff on the Omnicell.

Questions included those about the security of the system, especially during power failure.

Surveyor then requested to see the crash cart. He was particularly concerned about crash cart capabilities for pediatric patients since the ward takes pediatric patients as well.

Ambulatory Procedure Unit

Surveyor walked through the pre-operative process.

A pre-op chart was reviewed and the surveyor questioned why the history and physical hadn't been updated within 7 days.

Operating Room

Surveyor toured the pre-operative area, PACU and OR.

Surveyor asked a SPC in the PACU to walk him through the process from when a patient enters the unit through discharge.

Surveyor then asked him about 91W training and how he was oriented to the unit when he arrived.

Are patients checked up on once they leave the PACU?

Radiology

The Surveyor continued the DVT tracer who had undergone an ultrasound.

The Chief of Radiology met the surveyor and brought him into the reading room.

The surveyor was shown the DINPACS system and the ultrasound results from the DVT patient were pulled up. The surveyor spoke with the radiologist that did the ultrasound on the DVT patient. He asked if the patient was cooperative and if he had been briefed by the ER staff as to the problems they had documented on the 558.

The surveyor was interested in the DMLSS system and particularly how the department of radiology ordered contrast.

The surveyor asked if a reaction to contrast would be considered a medication error.

The surveyor stated that many facilities now are ordering contrast through the pharmacy, but didn't criticize our process.

The surveyor was then led into the quality control room where he conversed with the radiology technicians. He picked one tech to take him to a CT scan machine.

The surveyor asked the technician how she kept current on training and how she could get additional training if she wanted it.

Surveyor requested to see the MRI located in the basement.

Spoke with the receptionist and wanted to know how patients got scheduled for MRIs and how the prioritization was accomplished.

Surveyor then spoke with the MRI technician and asked questions about emergencies in the MRI suite and whether they use sedation.

Surveyor then reviewed the daily schedule and questioned the tech on the process for prepping patients.

Surveyor then asked questions about the crash cart in the MRI suite.

Surveyor asked if the technician knew who would come when the code was called.

Nurse Surveyor Activities

A summary of the questions and tracer activities follows:

Patients Traced: (1) Chest pain; (2) OB/C-section; (3) pancreatitis

Specific areas of interest: Patient assessments, Advance Directives, Medication Management, Competencies, Patient teaching, Patient After care/Discharge plan, Security (Meds/Peds).

Intensive Care Unit

How long have you worked here?
How old is the patient?
What was the date of admission?
How did the patient come to your section (ex? From home, ED, another ward)?
Are ED notes online?
What's the history on this patient?
What were the patient's lab results?
What is being done for this patient?
What was the initial assessment of this patient?
Does this patient have Advance Directives, if yes, who discussed them with patient and is it documented?
Do you document a response if patient doesn't have Advance Directives?
What action would staff take if patient had nothing documented to show they had an Advance Directive or that one had been discussed?
Does the dietician interview your patients?
What is the policy on patients seeing a dietician; how long would it take?
When notes are entered on electrons, is the consult generated automatically or does the provider put in a separate order (i.e., needs to see dietician, requires smoking cessation class)?
How is the functional assessment for pain measured?
How often are vitals done?
Does this patient have any allergies?
What meds are she on; does she take meds at home?
What type of orientation did you have when you came on board; did you have a preceptor?
How many beds are on your unit; how many staff nurses are assigned?
Do you ever do 1 to 1 care?
Take me through your medication processes of giving a patient their meds?
What meds are on your floor?
Head Nurse asked, how do you know your nurses have set their monitors at the right setting?
Can you suspend an alarm on a monitor; can you silence a monitor?
If orders are all on electrons, how do you sign off on it?
Will the system accept an illegal abbreviation?
Have you ever found one in the orders; what would you do if you found one?
In terms of this patients stress, what support is being offered?
(Surveyor requested to review ED chart; inquired about pain assessment on ED Form)
5 ED records requested
How does it work, giving meds after hours?
What action would you take if you needed a med that was not stocked on the floor or the pharmacy was closed?

What are the pharmacy hours?
What was the patients discharge assessment?
Was patient seen or referred to Social Work Service?
Was patient placed on any additional medications?
Do you do follow up calls on patients after discharge?

Dietician asked:

How do you get consults?
Do your techs screen 100% of consults?
What if it's a weekend, are you reachable?
Do you screen the admissions list?
What do you do about herbals?
What's most challenging with patients here?
Do you have someone who consults with new mothers?
Do you do discharge plans on all inpatients?
Do you document on electrons?

Pharmacy

What is your process for after hours medication request?
How do you decide what goes in them?
Is there any drug the floors can give without pharmacy review?
Are you going to profile on Omnicells?
Do you do 100% reviews each morning?
Are all staff issued passwords to access Omnicells?
When staff leave, how do you remove their code; what's the time frame for that removal?
Can you provide a list of staff, current and departures?
How do you manage unapproved abbreviations?
Can you stop entry of unauthorized abbreviations?
Do you get data from PI or anyone on abbreviations?
Do you have staffing problems?
Are there any high alert meds on the floors?
Why are nurses mixing Pitocin (this is an Infection Control as well as a Patient Safety issue?)
Surveyor requested competencies on L&D staff

Emergency Department

How are patients brought into the ED?
Where are patients triaged?
How many beds are in the ED?
Is Fast Track open 24/7?

Are staff ACLS trained?
Where does contract staff come from?
How do you know if contract staff have necessary competencies?
Do you verify skills on contract?
Do you keep their files here?
Does the bottom of the ED form count for discharge to home or ward?
Where is pre-discharge pain assessment documented?
Would you expect a zero on patients who did not require pain assessment?
Do you use a cry scale; is it converted into a number?

OB/ Mother-Baby

How many beds are in your area?
Do you do LDRP?
Do you do C-sections (L&D or OR)?
Do babies stay with the moms?
Where do you get her prenatal charts from?
Who does her prenatal care?
When does she get an ultra sound?
Do you have an NICU or do you transfer?
Who does the initial assessment after delivery?
Do you get Advance Directives on all patients?
How do you know patients are bonding well with their infants?
Do you have a lactation specialist?
What was the admission date of this patient?
When will patient be discharged?
How do you do patient teaching?
What are the ward rules?
What's a patient care responsibility?
Do you instruct patients on infant care?
What training is done to prevent abduction?
How long from top to bottom does it take an abductor to get out?
What support does mom have after she goes home?
Does anyone talk to mom reference nutrition; what about for the infant?
How do you protect yourself from overly excited or unhappy family members?

Labor & Delivery

Do you do C-sections?
If you had a crash where would it go?
Does patient go through ED or come direct to you?
Are staff competent in fetal monitoring; how often are they trained; is someone required to be certified on every shift?
Why was the decisions made to do a C-section on this patient?

Does Pitocin come from the pharmacy premixed?
Do you mix any other meds (Gentamycin)?
Surveyor requested to review the anesthesia chart?
Where is the "Time Out" documented; where would you find pre-assessment and pre-induction?
Do you manage epidurals?
How would I know who was in the room?
How do I know the provider was in the room?
Are you trained to circulate; were you trained for that?
When do you get prenatal charts?
Do you keep meds in the C-section room?
Do you refrigerate meds here?
Do you keep them secured?
What if the infant is having trouble and has to be transported, do you have a special transport team?
Does mom go if the infant is transported?
Is Dad allowed in the room during a C-section?
On average, how many C-sections do you do?
Are moms allowed to select C-section as 1st option (this may become a patient right issue)?

Surveyor spoke with patient:

How was the labor?
When will you be going home?
Do you have family close?
Did you anticipate any problems?
How has your care been?

Surveyor then asked the Head Nurse about circumcision and how is the infant prepped for the procedure

Medical/Surgical Ward

Inquired about a cellulitis patient (not a scheduled tracer)
Do you have pediatric patients?
Inquired about Head Nurse's background
Is patient a diabetic (nothing shown in electron history)?
Did patient have NG tube?
Has a nutritional assessment been done on this patient?
Do you document rounds?
How often do you do rounds?
What glucose device do you use?
Does lab train your staff?

What is your feeling regarding this patient. . .will she start eating?

Admin Surveyor Activities

A summary of the questions and tracer activities follows:

Following the Opening Session the Admin surveyor called for a Facilities and Management Meeting. This is a summary of that meeting.

Reviewed the Part 4 Plans for Improvement

- asked about nonconforming doors
- asked about nonconforming penetrations
- asked about projected completion dates
- requested copies of the Part 4 PFI forms and floor plans

Planned building tour

- stated that minor observations may be corrected on the spot and not count as a finding
- asked about square footage and fire separations
- requested 6 ft ladder, flashlight and batteries for tour
- asked about exit stairways
- asked about fire alarm panels and sprinkler pumps
- asked about hazmat storage areas
- asked about mechanical/electrical/telephone closets
- specified to the team what would be examined on each floor

Discussed EOC System Tracer expectations

- "show me" hard data
- PM completion rates, user error management, unscheduled work orders, equipment history, generator testing, PM indicators, etc.
- indicated the key to data collection as "what is being done with it"
- indicated that figures and data would also be expected at the Data System Tracer session

Building Life Safety Code Tour

- 6th floor
 - 4 vertical pipe and wire conduits not identified on SOC
- 5th floor
 - no findings, but recommended some wire conduits filled in
- 4th floor
 - 2 vertical pipe penetrations identified on SOC
 - fire separation penetration identified outside Ward 4A
- 3rd floor
 - vertical conduit in electrical closet identified
 - fire separation visible only from one side; recommended filling in even though discussed sealing on opposite side of penetration
 - 2 wire conduits and 2 holes identified
- 2nd floor
 - major pipe conduit identified and recommended for repair/filling

- B201 fire door warped
- 2 vertical conduits identified in mechanical closet
- 1st floor
 - asked about fire alarm panel with regards to self-diagnosis, monitoring and managing
- Basement
 - no findings in linen, loading dock or hazmat
 - items noticed on both sides of the hallway in addition to non moveable chairs
 - requested NFPA requirements for sprinkler pump testing requirements—**IOU**
 - requested documentation of testing—**IOU**
 - no findings in kitchen

Family Health Clinic

indicated bathroom pull cord needed to be longer
 identified burned out light bulb in storage closet
 requested access to electrical closet

Met with Staff Physician, Resident, Medical Assistant, 2 RN's and an LPN:

remarked "good job" on problem list
 asked about each individual's role in the facility
 asked about ht/wt/head circumference policy with babies
 asked what was being done to prevent abductions to include drills involving clinics and ED
 asked about pain assessment on infant
 asked about transfer of care from clinic to inpatient care provider
 interested in diabetic teaching and specifically evaluation of effectiveness
 indicated that measuring # of unscheduled ED visits better indicator than lab values of diabetic teaching effectiveness
 asked about tracking of adverse drug reactions and definition thereof
 suggested expanding definition of adverse drug reaction to *possible* adverse drug reactions to include anything **unwanted or undesirable**
 suggested asking patients "have you ever experienced..." rather than "are you allergic to..."
 asked about appointment back logging
 asked about patient load and % referred out
 asked or offered national averages and asked for the comparison of our data to the national average
 encouraged competition with the national average
 asked about waiting periods for patients from appointment time to seeing a physician
 asked about no show/cancellation rates and correlations with specific providers
 asked about sample meds

asked if staff were familiar with National Patient Safety Goals
asked if equipment with alarms had been tested against competitive noise
encouraged more med error reporting

Internal Medicine

indicated bathroom pull cord needed to be longer
requested patient record who had been seen today
asked about patient load
asked about staffing composition
met with Medical Assistant:
- self description of role
- pain assessment in case of dementia

Pediatric Clinic

indicated bathroom pull cord needed to be longer
requested pt record who had been seen today
asked about patient load
asked about staffing composition
asked about residency rotation
met with LPN:
- self description of role
- pain assessment to include dementia and infants
- suggested use of 10 pt FLACC scale (face, legs, activity, crying, consolability)
- policy on ht/wt/head circumference
- temp technique on infant and policy
- steps taken to prevent child abduction
- asked about certification for waive testing (urine dipstick testing)
- reviewed CBA folder
- asked for control log for waive testing
suggested master list of personnel qualified to perform specific waive tests

Survey Day Two – 19 May 2004

Physician Surveyor

A summary of the questions and tracer activities follows:

Operating Room

Surveyor requested to go into a scheduled surgery and the patient consented.

Spoke with the patient and asked which side his hernia was on and how the patient knew.

Reviewed the patient's note in CIS.

Stressed the importance of the post-op note being done by the surgeon prior to the patient being taken into the recovery room.

Asked about the requirements for the nurses in the recovery room in terms of training.

Entered the OR and queried the surgery staff how they knew the equipment had been PMCS'd.

Discussed OR fires and the importance of the sentinel event letters.

Asked about wrong site, wrong procedure surgeries and properly identifying the proper site.

Asked about the Omnicell and how narcotics were maintained in the OR.

Emergency Room

Surveyor stopped two of the contract EMS staff in the halls of the ER waiting room. Asked them about their dual mission of 911 support on post and transport missions.

Surveyor wanted to complete the tracer from day one on the DVT patient.

Asked about staffing in the ER.

Asked about the contract ER physicians and how the Director handled the hiring and firing process.

Questioned the ER board displaying names and asked if it was a HIPAA violation.

Asked about securing the facility and he was told that the ER was staffed 24/7.

Spoke with a (PA) about post deployment health screenings and his credentials file.

Asked how respiratory therapy was utilized in the ER.

Asked about ER diversions.

Nurse Surveyor

A summary of the questions and tracer activities follows:

Patients Traced: COPD

CVA with dehydration

Newborn with decreased weight and jaundice

Specific Areas of Interest: Pain management, medication management,
Competencies (peds / lab / respiratory therapy)
Advance Directives on inpatients

Medical/Surgical Ward

When did patient get 1st dose of antibiotics?
When did she arrive to the unit?
What was the patient's assessment?
Is patient on pulse ox?
How are the patient's lung sounds?
Will patient be referred for counseling?
Is patient on meds?
What is the plan of care?
Does patient have Advance Directives?
How do you get report on your patients?
How do you get reports from the ED?
Is patient on Respiratory Therapy?
Do you give RT meds?

Surveyor inquired of the escort, what do we have regarding range orders; how do we deal with range orders; at what point does staff intervene?

Emergency Room

If patient's pain level on initial assessment was ten, when would you reassess pain?
Would you only document if pain was greater?
Do you have a policy in ED that requires pain reassessment on discharge?

Respiratory Therapy

How do we do RT service?
Do nurses do RT on the floor?
How do you target who to train?
Do you do inservices and check them off; how often do you reassess them; do you document direct observation?
When you check them off, how do you evaluate them; do they do hands on?
Did you tally data to determine who to train?
Do you do vents?
Would I see ABG on the floor?
How long has this been in transition?
Are you measuring patient outcome?
If a patient coded on the floor, what were the previous assessments?
Who responds to that code?

Intensive Care Unit

Patient traced was an 84 year old CVA with dehydration

Inquired about history?
Is spouse alert?
How is spouse when he comes in?
When was patient admitted?
What is provider's thought / anything acute?
What kind of outcome would you expect from your care plan?
Are other disciplines seeing patient?
What meds is the patient on?
What's the patient heart rate; blood sugar; was a pulse ox done?
What do you do with a verbal order?
Do they dictate ED reports?
What was admission assessment?
Does the patient have an Advance Directive?
How does assessment for allergy get down to pharmacy?

Surveyor spoke with Head Nurse:

Do you have staffing issues?
Have you collected data to justify having on-call staff?
Are they paid to be on call?
Did staff behavior change?
Did you find correlation with care parameters?
What's the next step with data?

Pediatric Clinic

Tell me about your clinic?
What age groups are seen here?
How do they get appointments?
Who does phone triage; what are their hours?
Do you have patient records here prior to appointments?
What does screening consist of?
How do you clean equipment in lobby, especially books?
Has infection control looked at cleaning books?
What do you do in the event of a code?
Are triages 24 hrs?
What's the difference between kids seen in Family Health Center and Peds?
If a patient hydrates and bilirubin stays up, what's the plan?
How does mom feel about supplemental feeding?
How does mom feel about breast feeding?
Does mom have family in the area?
How does telephone triage work?
If a patient calls 800 advice line how do you know disposition?

What training did you have to work here (Head Nurse)?
Do you train new staff?
Are you PALS certified?
How would you evacuate if there was a fire?
What if the child was not mobile?
Have you had a child come up missing; what action would you take?
If a child is walking vs. infant, is that identified when code is called?

Lab

Tell about point of care testing
If certifications expire can you access the system?
Do you notify staff; how long?
Are ABGs done in the lab; from what areas?
How do ABGs come to you?
Does computer generate the specimen label or is it hand written?
What's the process for type and cross; transfusion?
How does emergency release take place?
How often are staff competencies verified?
Do you have phlebotomy?
When would nurses draw blood; who trains them?
Are hemolyzed specimens from ED a problem?

Admin Surveyor

A summary of the questions and tracer activities follows:

Rader Family Health Clinic

Commander Conference Summary

asked about admitting policy to inpatient facilities and which facility determined how
asked about admitting privileges
asked about ambulatory surgery
asked about maintenance of competencies
asked about staffing composition
asked about enrollment and annual demands by member
encouraged data collection on unscheduled visits specific to disease process
asked about appointment time/access standard, then waiting time to see physician and no show/cancellation rates

Rader Family Health Clinic, Pediatric Clinic

asked about ht/wt/head circumference policy
indicated books in waiting area were infection control issue

Rader Family Health Clinic, Physical Therapy

examined medical record
- no indication of problem summary list
met with PT assistant:
- reminder to make treatment goals and objectives measurable, time frame specific and defined in behavioral functional terms
- reminder to bear in mind Medicare standards
- encouraged to relate functional goals in terms of tying shoelaces, etc.

Rader Family Health Clinic, Behavioral Science

Met with 91X
self description of role
staffing composition
chain of command

Rader Family Health Clinic, Lab

Met NCOIC
hours of operation
impact of power outage
what equipment are supplied by backup generator power
how are they identified
became more interested in generator once established that only some refrigerators were backed up, and outlets were not clearly marked as being on generator power

Rader Family Health Clinic, Immunization Clinic

interested in which fridges were supplied by generator power

Rader Family Health Clinic, Adult Wellness Center

Met with dietician
asked about DM education and inquired about effectiveness indicator
suggested tracking unscheduled visits to physician as indicator

Rader Family Health Clinic, Primary Care Clinic

asked about hours of operation

Met with 91W

self description of role

pain assessment to include multiple sites, varying degrees, disorientation
and unrelated symptoms to reason for visit

Rader Family Health Clinic, Radiology

Met with NCOIC

asked about availability of images within the clinic

asked about suspense date on eliminating paper charts

Rader Family Health Clinic, Specialty Clinic

staffing composition

Rader Family Health Clinic, Primary Care Clinic

staffing composition/any residents

Met with RN and MA

self description of role

asked about pain assessment

asked about screening and what to do with BP outside normal limits

reviewed chart and observed documentation

inquired about extent of questioning patient about home meds to include
herbals and foods

Rader Family Health Clinic, Pharmacy

Met with OIC

asked about average wait time

asked about # of lines carried

asked about annual purchases, inventory on shelves, and annual turnover

asked about interventions and reasons

asked about adverse drug reaction reporting

asked about med error reporting

asked about military vs. civilian prescriptions filled at this pharmacy

suggestion to increase turnover from current 6 to approx 10, compared to
national average of 8-12

Rader Family Health Clinic, Emergency Power Generator

asked about 50% calculated load, excess capacity
suggested diverting power from non essential lighting to fridges and other equipment better served by backup power
recommend outlet plugs be identifiable on sight connected to generator

DeWitt Radiology

demonstrated “stealing” a portable X-ray machine
suggested making duplicate keys for techs to keep machine secure when stored

DeWitt Physical Therapy

Met with OIC:

asked about staffing composition
asked about OT
asked about workload
asked about backlog, no show/cancellation rates
reviewed medical record
- revisited education on treatment goals and objectives being measurable, time frame specific and expressed in behavioral functional terms
- 1 unauthorized abbreviation noted
suggestion to give example of each expressed goal/objectives to clarify for patient
suggestion to avoid medical terminology in outpatient chart

DeWitt Subspecialties Clinic

Met with OIC

asked about clinic composition
asked about staffing composition
asked about meds in RT storage room
looking for RT with unsecured meds

Survey Day Three - 20 May 2004

Physician Surveyor Activities

A summary of the questions and tracer activities follows:

Surveyor requested to see the previous four quarters from the medical records delinquency report.

Surveyor requested to visit the Intensive Care Unit to see a patient who was admitted for a rule out MI.

DeWitt Intensive Care Unit

Requested to talk to staff who was the nurse treating the patient.

Reviewed the 558 from the ER where the patient entered the facility and then reviewed the CIS notes.

Requested to see the patient and the patient consented.

Asked Head Nurse about staffing the ward and how the staffing level was decided upon.

Requested to see the residents on the ward and then quizzed the residents on credentialing, length of their program, board certification, and outside rotations.

Requested to visit a cellulitis patient on Medical/Surgical ward

DeWitt Medical/Surgical Ward

Reviewed the note in CIS and looked particularly for the immediate post-op note.

Asked to speak with the patient, and the patient consented.

Requested to return to the Phase I recovery room.

DeWitt Medical Maintenance

Survey walked through the DMLSS system and the process for tracking medical maintenance services.

How do the users know whether the equipment had been checked and was in good working condition?

What was your involvement was in the recent Sentinel Event, OR fire?

Tour of the repair shop where he made conversation with several of the medical maintenance technicians and asked about the National Patient Safety Goal concerning infusion pumps.

Nurse Surveyor

A summary of the questions and tracer activities follows:

Fairfax Family Health Clinic

Inquired about optometry patients; are they referred out?

Inquired about hours

Is there any staff category that's hard to get filled through contract?

Are you monitoring patient wait times in the clinic and on the phone?

Has there been a trend in no show rate?

Most common reason for no show?
Do you tell patients their responsibilities for no show accountability?
What's pharmacy doing for PI?
Do you measure wait time at pharmacy?
Explain check-in process?
Where does patient go after check –in?
What happens to records when they are retired?
How long have medical assistants been teamed with providers?
Are meds kept in screening area?
How do Bio Hazard items get taken out?
Do you have chemo patients treated here?
What action is taken if a patient codes in the triage room?
What training did you have to come here?
What about on going training?
If you had a patient to act kind of off how would you react?
How many providers are caring for patients each day?
If a patient comes in highly contagious what do you do with them?
Where does PI data go; what do you do with it?
Surveyor spoke with healthcare liaison; do you arrange transportation for patients; do you schedule specialty appointments?
Who does follow up calls on patients?

Fairfax Family Health Clinic, Lab

How do you match patients with specimen?
Are labels computer generated?
Do you use bar codes?
Does lab come under CAP?
Do you recertify once certified?
Do you do PI on specimen labeling; do you aggregate data?
Are staff tested for color blindness?
What type of on going training is being done?
Do you have an eyewash station?
Do you have a shower?
How do you label specimens?
Do you check ID?
How many patients per day do you see?
In relation to PI, what was your outcome; do you know what you were going after?

Fairfax Family Health Clinic, Radiology

How do you ID a patient to ensure right patient?
Do you have hard copy request?

How do you know you're doing the right side?

Fairfax Family Health Clinic, Pharmacy

Do you do IV's?

How do you get allergy info on patients?

Do you have automated records?

How many pharmacist and techs do you have?

What would you do with illegal abbreviations sent by a provider?

Do you report interventions in med/marks system?

What if a patient asked about the dosage vs. what was given?

Do you get experimental drugs?

What about sound alike and look alike items?

How are narcotics secured after hours?

What do you do in the event of a code red?

How often do you practice for codes?

What pain management scale do you use on pediatric patients?

Admin Surveyor

A summary of the questions and tracer activities follows:

Woodbridge Family Health Clinic

Commander Conference

asked about typical waiting pd for pts to get appointment, then to be seen on appointment

asked whether held to DeWitt policies, or civilian

asked about staff familiarity with National Patient Safety Goals, sentinel event indicators and FMEA

asked about outpatient adverse drug reactions

asked about fire drills/annual disaster drills

asked about coordination with civilian facilities

asked about appointment system

asked about patient load and physician "control" of pts when consulting specialties (focus being continuity of care and fiscal retention)

suggested offering pt reading material, returning to waiting area or rescheduling appointment if Dr is running behind (focus on not abandoning pt)

asked about no show/cancellation rate; kudos for data collection; offered goal of less than 10% (single digits=good, teens=watch, >20%=act)

offered suggestion of letters to commanders/employers to encourage accountability for appointments

asked about sample meds

asked about physician admitting privileges
asked ages of physicians
asked about competencies and physical abilities of staff
asked about new employee orientation and education of recognizing and reporting "impaired provider"; encouraged education of all staff to include housekeepers

Woodbridge Family Health Clinic, Pharmacy

asked about prescriptions written by Woodbridge physicians
asked about waiting time
asked about pharmacy interventions and data tracking
asked about annual purchases, inventory and turnover
asked about tracking of possible adverse drug reactions
 -suggested defining as "unwanted/undesired"
suggested tracking facility-wide med errors beyond pharmacy alone
asked about crash carts
 - suggested biggest area for improvement being ambulatory care

Woodbridge Family Health Clinic, Physical Therapy

asked about chain of command
asked about credentialed personnel
asked about equipment available in PT
asked about staffing composition
toured pool and asked maintenance questions/ reviewed pH alkaline reports and maintenance log
asked maintenance questions about pool to include back flushes, calcium treatment and suggested viewing window

Reviewed PT chart

missing documentation of patient stated goals and education
identified non approved abbreviations
missing qualitative reflection of reduction in pain
treatment goals not expressed in behavioral functional terms

Woodbridge Family Health Clinic, Behavioral Health

Met with supervisor:

asked about mission, services and staffing composition
asked about intensive outpatient and admissions process
asked about patient load
asked about types of therapy groups (sizes and frequency)
suggested motion therapy and acupuncture

asked if interaction existed with ambulatory care on how to recognize signs of abuse
observed pictures on walls not anchored

Woodbridge Family Health Clinic, Radiology

asked about mammography on men
asked about diagnostic studies
asked about workload and staffing composition
asked about response time on image reading

Woodbridge Family Health Clinic, Lab

asked about total # tests ordered and % kept in facility and % sent out
asked about benefits of coban

Woodbridge Family Health Clinic, Treatment Room

reminded of standard 300 cu ft limit of medical gases in non-rated room for medical gas storage

Met with LPN

self description of role and contract
asked about screening process

Met with MA

self description of role
asked about screening process
asked about waiting period for pt before being seen by physician
suggested offering pt choices when physician is detained

Met with patient educator

asked where pt ability/willingness/preferences/barriers to learning were documented
suggested single sheet with all learning and education documented
asked if responsible for both patient and staff education
asked about competencies
cautioned careful investigation/verification of licensure

Reviewed CBA folder

asked about variation between RN and LPN competency checklists
asked to see initial and annual competency evaluations

Reviewed medical record

- incomplete problem list noted

Root Cause Analysis Review with Operating Room Staff

1. Expectation was to hear about action plan and review
2. Engaged in discussion about lessons learned, actions taken and data collected
3. Identified main concerns
 - a. have you reviewed pertinent literature
 - b. how has orientation of new personnel now changed
4. Encouraged discussion to make personnel uncomfortable to ensure digging as deep as possible to answer "why"
5. Expected to see more opportunities for error identified
6. Described process
 - a. look for opportunities for error identified
 - b. identify priorities
 - c. approximate cause
 - d. identify lessons learned and actions taken in response
7. Suggested publication of findings in interest of obligation to share knowledge gained
8. Asked about current training and frequency
9. Identified OR as highest risk area of hospital
10. Suggested/encouraged stronger literature review

Special Issue Resolution

Deficiencies noted on tour corrected with photos and documentation
IOU generated on last semi annual alarm check
IOU to update current semi annual alarm check
Suggestion to combine annual and semi annual check

Survey Day Four – 21 May 2004

All surveyors attended the Leadership Session in the morning. This session replaced the daily briefing.

Physician Surveyor

A summary of the questions and tracer activities follows:

Requested to visit the ER to discuss patient decontamination.
Surveyor was walked through our system and was shown the pavilion, which serves as the decontamination site.
Has anything changed since September 11

Physician Surveyor next attended the Credentialing and Privileging Session

Following the session, he followed with the Surveyor Report Preparation

Nurse Surveyor

The Nurse Surveyor activities began with the Leadership Session, followed by the Competence Assessment Session and Infection Control Session. Following the sessions, the Surveyor Report Preparation

Admin Surveyor

The Admin Surveyor started the day with the Leadership Session. Then followed with tracer activity. A summary of the questions and tracer activities follows:

Emergency Department

- discussed admission process
- discussed phys vs. nurse roles
- asked about the ED form and placement of the original
- asked how to read the ED form
- asked about pain assessment/intervention and documentation
- asked about home medication screen, including herbals
- asked about allergy screen, including food

Radiology

- suggested enclosing clean linen behind cabinet doors in changing rooms rather than sitting out on bench
- asked to see tests done on traced patient
- visualized CT
- asked about hours of service and radiologist duty hours
- asked about staffing composition and help available with starting IVs
- asked about allergy screen in radiology
- asked about central line infection tracking (N/A)

Medical/Surgical Ward

- asked surgeon about surgical expectations for the pt
- asked about expected time in OR
- asked about pre op H&P, anesthesia assessment and plan
- asked to see nursing admission assessment
- asked about CIS and its availability

No findings but suggestions noted with CIS:

- Suggested default phrases be eliminated from computer (not erased on assessment where necessary)
- Suggested adding food/drug and herbals on medication screen
- Suggested adding criteria based abuse screening

- Suggested yes/no checklist on computer charting
- Suggested a design that would not allow progression to the next section of charting until completion of the previous

-----**TERMINATION OF SURVEY**-----